

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10327 282

### 1. PLACE OF DEATH:

County St. Marys  
 City or town Castle  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County St. Marys  
 City or town Chesley  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.   
 (If rural, give LOCATION)  
 2(a) If veteran, name war

### 3. (a) FULL NAME

Thomas Elizabeth Armstrong

### 3. (b) Social Security Number

4. Sex Female 5. Color or race caucasian 6. (a) Single, married, widowed, or divorced widow  
 6. (b) Name of husband or wife James E. Armstrong  
 7. Birth date of deceased (mo., day, yr.) Feb 21, 1902 6. (c) If alive, give age  years  
 8. AGE: Years 45 Months 9 Days 10 If less than one day  hrs.  min.  
 6. Birthplace Chesley, St. Marys, Md.  
 (Town, county, and state)  
 10. Usual occupation housewife  
 11. Industry or business

12. Name Anderson  
 13. Birthplace   
 14. Maiden name Elizabeth Stewart  
 15. Birthplace St. Marys, Md.  
 16. Informant Janetta Mason  
 Address Cabley, Md.  
 17. Burial Date thereof 12/3/1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory St. Pauls  
 Location Bushwood Trch.  
 18. Funeral director W. L. Gatti, Chesley, Md.  
 Address Chesley, Md.  
 19. 47 Chesley  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 19 47, at 11:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 29 19 47, to Nov 30 19 47,  
 and that I last saw him alive on Nov 29 19 47  
 Immediate cause of death Pulmonary Thrombosis  
 Due to   
 Due to   
 Other conditions   
 (Include pregnancy within 3 months of death)

Major findings of operations  Date of op.   
 Autopsy results   
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  Date of   
 Where did injury occur?  (City or town)  (County)  (State)  
 Injured at home, farm, industry, public place (where?)   
 Means of injury  Injured at work?   
 23. SIGNATURE Barth A. Gaudin M. D. or other   
 Address Chesley, Md. Date signed 12/1/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CENTROCENTRAL DEATH

RECEIVED  
DEC 3 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 103282

<b>1. PLACE OF DEATH:</b> County <u>St. Marys</u> City or town <u>near Leonardtown md</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>37 years</u> Hospital, institution, or street address where death occurred: <u>Leonardtown md</u> How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>St. Marys</u> City or town <u>near Leonardtown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____			
<b>3. (a) FULL NAME</b> <u>Charles H. Connelly</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Male</u> <b>5. Color or race</b> <u>White</u> <b>6. (a) Single, married, widowed, or divorced</b> <u>married</u>				<b>MEDICAL CERTIFICATION</b>			
<b>6. (b) Name of husband or wife</b> <u>Frances J. Connelly</u>				<b>20. DATE OF DEATH</b> <u>Nov 18</u> 19 <u>47</u> at <u>5:00 p.m.</u>			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Oct. 6, 1874</u> <b>6. (c) If alive, give age</b> <u>73</u> years				<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Nov 18 1947</u> <b>to</b> <u>Nov 18 1947</u>			
<b>8. AGE:</b> Years <u>73</u> Months <u>1</u> Days <u>11</u> If less than one day _____ hrs. _____ min.				and that I last saw him alive on <u>Nov 18 1947</u>			
<b>9. Birthplace</b> <u>Alexandria Va</u> (Town, county, and state)				Immediate cause of death <u>Cerebral Arteriosclerosis</u> DURATION _____			
<b>10. Usual occupation</b> <u>waterman</u>				Due to <u>arteriosclerosis</u>			
<b>11. Industry or business</b> _____				Due to _____			
<b>MOTHER</b> <b>12. Name</b> <u>James Connelly</u>				Other conditions _____			
<b>13. Birthplace</b> <u>unknown</u>				(Include pregnancy within 3 months of death)			
<b>14. Maiden name</b> <u>Ellen Pillsbury</u>				Major findings of operations _____			
<b>15. Birthplace</b> <u>unknown</u>				Date of op. _____			
<b>16. Informant</b> <u>Mrs. Charles Connelly</u>				Autopsy results _____			
Address <u>Leonardtown md</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
<b>17. Burial</b> <u>Burial</u> Date thereof <u>Nov 20 1947</u> (Burial, cremation, or removal. Which?) (month) (day) (year)				<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:			
Cemetery or crematory <u>St. Paul Mc. Cemetery</u>				Accident, suicide, or homicide _____ Date of _____			
Location <u>Leonardtown Maryland</u>				Where did injury occur? _____ (City or town) _____ (County) _____ (State)			
<b>18. Funeral director</b> <u>W. C. Mallery Sons</u>				Injured at home, farm, industry, public place (where?) _____			
Address <u>Leonardtown Maryland</u>				Means of injury _____ Injured at work? _____			
<b>19. 11/20 1947</b> <u>Accidental</u> (Date rec'd by registrar) Registrar				<b>23. SIGNATURE</b> <u>Francis F. Greenwell</u> M. D. or other _____			
				Address <u>Leonardtown Md</u> Date signed <u>11-18-47</u>			

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
NOV 21 1947  
WT RFA

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10329

## CERTIFICATE OF DEATH

Reg. Dist. No. 25

### 1. PLACE OF DEATH:

County St. Mary's  
City or town Hollywood Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County St. Mary's  
City or town Hollywood  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Charles H. Corkran

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of ~~husband~~ wife Lena E.  
7. Birth date of deceased (mo., day, yr.) April 1, 1890 6. (c) If alive, give age 48 years  
8. AGE: Years 57 Months Days If less than one day  
hrs. min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1947 at 9:30 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947 to Nov. 25 1947  
and that I last saw him alive on July 1 1947  
Immediate cause of death Coronary occlusion DURATION 10 Min.  
Due to Generalized arteriosclerosis  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Plumber  
11. Industry or business  
12. Name Charles Corkran  
13. Birthplace Unknown  
14. Maiden name Unknown  
15. Birthplace Unknown  
16. Informant Lena E. Corkran  
Address Hollywood, Md  
17. Removal Date thereof 11-26-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Spring Hill  
Location Eastern Maryland  
18. Funeral director Paul W. Stafford  
Address Eastern, Maryland  
19. 11/26 1947 Cornelius  
(Date rec'd by registrar) Registrar

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE Dr. J. P. [Signature] M. D. or other  
Address Lexington Park Md Date signed 11-25-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The corrected page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 28 1947

STRAUS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10330

1600

Reg. Dist. No. 262

## 1. PLACE OF DEATH

County St. Mary'sCity or town Hallsgrove  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 min.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County St. Mary'sCity or town Hallsgrove  
(If outside city or town limits, write RURAL and give nearest town)Street No. —  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

Infant Flewrick

## 3. (b) Social Security Number

## 4. Sex

g

## 5. Color or race

cal

## 6. (a) Single, married, widowed, or divorced

—

## 6. (b) Name of husband or wife

6. (c) If alive, give age — years

## 7. Birth date of

deceased (mo., day, yr.)

Nov. 17 / 47

## 8. AGE:

Years

Months

Days

If less than one day

hrs. 10 min.

## 9. Birthplace

md  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

Victor Flewrick

## 13. Birthplace

md

## MOTHER

## 14. Maiden name

Marion Jones

## 15. Birthplace

va

## 16. Informant

## Address

Hallsgrove, md

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

Hallsgrove, md

## 19.

(Date rec'd by registrar)

19

17

Camalier

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 19 47 at 10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 17 19 47 to Nov. 17 19 47and that I last saw him alive on Nov. 17 19 47

Immediate cause of death

Pulmonary Metastasis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

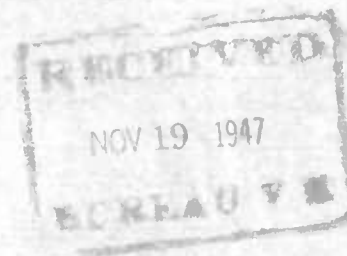
Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 11/17/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Marys  
 City or town Rural near Naval Air Station, Patuxent River, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Died immediately  
 Hospital, institution, or street address where death occurred: ---  
 How long in hospital or institution? ---

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys  
 City or town Patuxent River, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Naval Air Station  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war World War II

## 3. (a) FULL NAME

Robert Pershing Friesz

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Elizabeth J. Friesz  
 7. Birth date of deceased (mo., day, yr.) 5-18-18 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 29 Months 6 Days 2 if less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Missouri  
 (Town, county, and state)  
 10. Usual occupation U. S. Navy  
 11. Industry or business Naval Aviator  
 12. Name Arthur L. Friesz  
 13. Birthplace Unknown  
 14. Maiden name Unknown  
 15. Birthplace Unknown

16. Informant U. S. Navy  
 Address Patuxent River, Md.  
 17. Removal Undetermined  
 (Burial, cremation, or removal. Which?) Date thereof 11-21-47  
 Cemetery or crematory \_\_\_\_\_  
 Location Salisbury, Missouri  
 18. Funeral director Robinson's Funeral Home  
 Address Leonardtown, Md.  
 19. 11/20 47 Charles  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 20 November 19 47 at 1015 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_, and that I last saw him alive on 27 October 19 47

Immediate cause of death Injuries, multiple DURATION \_\_\_\_\_  
Extreme

Due to Aircraft accidentDue to undetermined origin

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-20-47

Where did injury occur? Near NAS Pat. River St. Marys Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Naval Air StationMeans of injury Aircraft accident Injured at work? Yes23. SIGNATURE Paul Vaughan M. D. or other \_\_\_\_\_

Address U. S. N. A. S., Patuxent River, Md. Signed 11-20-47

RECEIVED  
NOV 24 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10332

Reg. Dist. No. 281

## 1. PLACE OF DEATH:

County St. Marys  
 City or town Rural, Scotland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's  
 City or town Rural, Scotland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mattie E. Murphy

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife J. Spencer Murphy  
 7. Birth date of deceased (mo., day, yr.) Oct 21 1869 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 78 Months 0 Days 11 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace St. Marys Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife

## 11. Industry or business

MOTHER 12. Name William C. Bayne  
 13. Birthplace St. Ignace Maryland  
 14. Maiden name Susan Pembroke  
 15. Birthplace St. Marys Co. Maryland  
 16. Informant Mrs. Mary E. Tolp  
 Address Scotland Md.  
 17. Buried Date thereof Nov. 4, 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Trinity Church  
 Location St. Marys City, Md.  
 18. Funeral director W. C. Mottishaw Sons  
 Address Leonardtown Md.  
 19. Nov. 1, 1947 (Date rec'd by registrar) W. C. Mottishaw Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1947 at 12:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to Nov 1 1947  
 and that I last saw him alive on Oct. 31st 1947

Immediate cause of death General arterio sclerosis DURATION 5 years

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. C. Mottishaw M. D. or other \_\_\_\_\_  
 Address Great Mills, Md. Date signed 11-1-47

RECEIVED

NOV 5 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

157a

10333

Reg. Dist. No. 281

## 1. PLACE OF DEATH

County St. Mary'sCity or town Lionsardtown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

St. Mary's Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town Rural, Hollywood  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Infant Stiebel

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

Nov 22 - 1947

## 8. AGE:

Years

Months

Days

If less than one day

hrs. 20 min.

## 9. Birthplace

Lionsardtown, Md.  
(Town, county, and state)

## 10. Usual occupation

none

## 11. Industry or business \_\_\_\_\_

## MOTHER FATHER

## 12. Name

Le Roy E. Stiebel

## 13. Birthplace

Gypsum, Kansas

## 14. Maiden name

Ellen Boldenow

## 15. Birthplace

Bloomfield, Nebraska

## 16. Informant

Le Roy E. Stiebel

## Address

Hollywood, Md.

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

11-23-47  
(month) (day) (year)

## Cemetery or crematory

Jay Chapel

## Location

Hollywood, Md.

## 18. Funeral director

P. B. Robinson

## Address

Lionsardtown, Md.

## 19.

11-23-4747

(Date rec'd by registrar)

P. P. Bean, MD.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1947 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 22 1947 to Nov. 22 1947and that I last saw him alive on Nov. 22 1947

Immediate cause of death

DURATION

Cerebral hemorrhage 1/2 hr.

Due to

Due to

Other conditions

Hydrocephalus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

P. P. Bean, MD.

M. D. or other

Address Great Mills, Md. Date signed 11-23-47

RECEIVED  
NOV 29 1947  
BUREAU V R

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10334

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Piney Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State District of Columbia  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3241 1/2 St. N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Corney Irving Taylor

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Jeanne M. Taylor 6.(c) If alive, give age 45 years  
 7. Birth date of deceased (mo., day, yr.) Jan. 8, 1890  
 8. AGE: Years 57 Months 10 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Portsmouth, Virginia  
 (Town, county, and state)  
 10. Usual occupation Secretary  
 11. Industry or business Cluster Union  
 12. Name James T. Taylor  
 13. Birthplace Virginia  
 14. Maiden name Mary E. Ridak  
 15. Birthplace North Carolina

16. Informant Jeanne Taylor  
 Address Washington D.C.  
 17. Burial Date thereof 11-12-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Congressional Cemetery  
 Location District of Columbia  
 18. Funeral director Chambers  
 Address Washington D.C.

19. Nov. 10, 1947  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1947 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dead on arrival  
 and that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
 Immediate cause of death \_\_\_\_\_

DURATION  
Coronary heart disease 1 1/2 yrs  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE P. J. Bean, M.D. M. D. or other \_\_\_\_\_  
 Address Great Mills Ind. Date signed 11-10-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 13 1947

TYPE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... St. Marys  
 City or town..... Compton Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Life  
 Hospital, institution, or street address where death occurred:  
Compton Maryland  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... St. Marys  
 City or town..... Compton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Joseph Ford Turner

## 3. (b) Social Security Number

4. Sex..... male 5. Color or race..... colored 6.(a) Single, married, widowed, or divorced..... married

6.(b) Name of husband or wife..... Mary Emma Turner

7. Birth date of deceased (mo., day, yr.)..... March 14 - 1881 6.(c) If alive, give age..... 60 years

8. AGE: Years..... 66 Months..... 8 Days..... 11 If less than one day..... hrs. .... min.

9. Birthplace..... Compton St. Marys Maryland  
 (Town, county, and state)

10. Usual occupation..... Waterman

11. Industry or business.....

12. Name..... John Henry Turner

13. Birthplace..... St. Marys Co

14. Maiden name..... Brown

15. Birthplace..... St. Marys Co

16. Informant..... Mrs. Mary Emma Turner

Address..... Compton Maryland

17. Burial Date thereof..... Nov 28 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... St. Francis Xavier

Location..... Compton Maryland

18. Funeral director..... W. C. Mattingly Sons

Address..... Seaside Maryland

19. 11/27 1947 Cannalio  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 25 19..... 47 at..... 12:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 1946..... 19..... to..... Nov 25..... 19..... 47

and that I last saw him..... alive on..... Nov 23..... 19..... 47

Immediate cause of death..... Acute Myocardial Infarction

Due to..... Chronic Endocarditis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Frank A. Cannalio  
 M. D. or other.....  
 Address..... Seaside Md Date signed..... 11/27/47

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NOV 29 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

10336

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Marys  
 City or town Rural (Mechumsville)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County St. Marys  
 City or town R.T.D. Mechumsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joseph S. Wood

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Susan Wood

7. Birth date of deceased (mo., day, yr.) March 15, 1869 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation none

11. Industry or business \_\_\_\_\_

12. Name Henry Wood

13. Birthplace Maryland

14. Maiden name Marian Wood

15. Birthplace Maryland

16. Informant Susan Wood

Address R.T.D. Mechumsville

17. Burial Date thereof 11-10-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph

Location Maryland

18. Funeral director P. B. Robinson

Address Leonardtown, Md.

19. 11/10/47 Registrar Charles H. Huel

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1947, at 8<sup>00</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 23<sup>rd</sup> 1947, to Nov. 1 1947.

and that I last saw him alive on Nov. 1<sup>st</sup> 1947

Immediate cause of death \_\_\_\_\_

Due to chronic valvular

Due to heart disease

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Levin J. Sorkow

Address Charlotte Huel Date signed Nov 9, 1947

## DURATION

Decemal

9 years

RECEIVED

NOV 12 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10337

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County... *St. Marys*City or town... *Louenville Md.*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Maryland* County... *St. Marys*City or town... *Louenville Md.*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *L*  
(If rural, give LOCATION)2.(a) If veteran, name war *L*

## 3. (a) FULL NAME

*Mary Elva Young*

## 3. (b) Social Security Number

*L*

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*female* *colored* *widowed*

6.(b) Name of husband or wife

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

*Jan. 3**1881?*

8. AGE:

Years

Months

Days

If less than one day

*66?*

hrs.

min.

9. Birthplace

*Maryland*  
(Town, county, and state)

10. Usual occupation

*none*

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... *11/21/47*  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. *11/20*

(Date rec'd by registrar)

*47**Camelie*

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... *November 19* 19... *47* at *1:00* P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Oct 15* 19... *47* to *Nov 19* 19... *47*and that I last saw h... alive on *Nov 1* 19... *47*

Immediate cause of death

*Chronic nephritis*

Due to

Due to

Other conditions

*Hemiplegia*

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Frank A. Camalier*  
*Louenville Md*

M. D. or other

Address... Date signed *11/20/47*

RECEIVED  
NOV 24 1947  
STERN